Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE
Advancing Understanding. Improving Lives.
Avancer la compréhension. Améliorer la vie.

500 Church Street, Penetanguishene ON L9M 1G3
500, rue Church, Penetanguishene (Ontario) L9M 1G3
705-549-3181 www.waypointcentre.ca

Waypoint Centre for Mental Health Care

Family, Child, and Youth Mental Health Program
Parent/Caregiver Questionnaire

Instructions

FAX COMPLETED FORM AND ANY ACCOMPANYING DOCUMENTATION TO:

Waypoint Central Intake by fax to 705-549-1812 or by email to centralintake@waypointcentre.ca

Please complete this form to the best of your ability, include the following items with this questionnaire if possible:

a. A copy of the Custody agreement for your child, if applicable
b. Signed Release of Information Form
c. A copy of the most recent report card
d. Copies of occupational therapy, physiotherapy or speech therapy reports, psychological reports, psychiatric reports and school testing reports (or arrange for your family doctor to forward these if he/she has copies)

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Print Form Clear Form

Date: _____

FOR WAYPOINT USE ONLY	Date Received:		Account #:	

Client/Patient Information

Name of Person Completing Form:			
Name of Child/Youth (Last name, first name):			
DOB *(dd/mm/yyyy)*:		**Preferred Name:**	
Gender: ☐ Female ☐ Male ☐ Intersex ☐ Trans (male to female) ☐ Trans (female to male) ☐ Two Spirit ☐ Other (please specify):			
Preferred Pronoun(s):			
Health Card Number:		**Version Code:**	
Address:			
City:		**Postal Code:**	
Primary Telephone #:		**Alternate Phone #:**	
Who initiated this referral?			
Parent/Guardian/Caregiver Name:			
Address:			
City:		**Postal Code:**	
Primary Telephone #:		**Alternate Phone #:**	
Parent/Guardian Email Address:			
Interpreter required? ☐	**Language:**		
Pharmacy:		**Drug Allergy:**	
Any other Physicians involved (i.e., Paediatrician)?		**Issues Addressed:**	

Please describe the main concerns and behaviours which worry you:

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Child's Strengths: (Comment on talents, interests, skills, involvement in sports/clubs/or other activities, positive connections within the family, relatives, friends, and the community)

Main Stresses For The Child: (Have there been any major events, now or in the past, which may have been stressful to family, i.e., relocating, physical/mental illness or death, family breakdown, unemployment, violence, legal/financial problems (please identify)

Responding To Distress: (When your child is distressed, how do you, the parent/caregiver, respond)

Managing Behaviour: (When your child is misbehaving, how do you, the parent/caregiver, respond)

Traumatic Events: (Are you aware of any traumatic events that may have affected the child)

Do you have any questions you want answered?

1. _____
2. _____
3. _____

List other agencies ever involved with your child and years of involvement. Please provide note if available.

_____

_____

_____

Custody status if applicable:

- ☐ Joint
- ☐ Sole Custody
- ☐ Temp care agreement
- ☐ Other: _____
- ☐ Case Manager: _____

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Medical

Family Doctor: _____ **Tel #:** _____

Current medications, Special diets, vitamins, herbal supplements: (any over the counter) *attach list

Name and Dose	Response	Date Started / Discontinued	

Are you aware of any other assessments planned in the next 6 months? ☐ Yes ☐ No
(if yes provide the following)

When: _____ **Where:** _____ **By Whom:** _____

Child's Past Health Problems

	Age:		Age:	Other (Specify):	Age:
☐ Rash/Skin Problems		☐ Ear Infection(s)			
☐ Seizures		☐ Surgeries			
☐ Recurrent Infection(s)		☐ Meningitis			
☐ Head Injury					

Prenatal and Birth History and Early Development

Pregnancy Duration: _____ weeks. Was a doctor seen regularly: ☐ Yes ☐ No

Birth Weight: _____ Lbs _____ Ounces Was baby in an incubator after birth: ☐ Yes ☐ No

Any Complications?

_____

_____

_____

Delivery/Early Months:

Any Fetal Distress Prior to Birth: (explain)

_____

_____

Other Health Problems: (explain)

_____

_____

Were any of the following taken or used: ☐ Alcoholic Beverages ☐ Cigarettes ☐ Drugs/Illicit Substances

Prescription/non-prescription medication during pregnancy: ☐ Yes ☐ No

Medication Names: _____

_____

_____

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Childs First Year of Life: Check all that apply (generally describing)

- ☐ Curious and inquisitive
- ☐ Stiffened when held
- ☐ Easily startled/frightened
- ☐ Fussy, cranky
- ☐ Difficult to soothe
- ☐ Enjoyed cuddling
- ☐ Cried a lot
- ☐ Happy
- ☐ Poor Eating
- ☐ Poor Sleep
- ☐ Sound/Interested

Any problems encountered during the first few months of life: (explain)

_____

_____

_____

Child's Developmental Milestones:

As best as you can remember, at what age child reached the following milestones:

Sat up:		First Steps:	
Rolling:		First Words:	
Toilet Trained:			

Are immunizations up to date: (provide copy of record) ☐ Yes ☐ No

Eye Contact: ☐ Yes ☐ No Sharing: ☐ Yes ☐ No

Preschool and Early Years:

Did your child attend Day Care/Pre-School: ☐ Yes ☐ No

Did the child have difficulty with other children:
Did the child show unusual reactions to change in plans/routines:

Current School:

Does your child enjoy school?
Does your child get along with teachers?
Does your child get along with classmates?
Are there any school subjects they find especially difficult?

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Past and Current Community Supports and Assessments:

Occupational Therapy (OT)	
Physiotherapy (PT)	
Speech Language Therapy (SLP)	
Psychoeducational Assessment	
Community resources, etc.	
Audiology/Hearing	

Schools Attended	Year(s)	Grade(s)	Noted Strengths or Problems	Special Program(s)

Family History:

	Parent 1		Parent 2	
	☐ Biological ☐ Step ☐ Foster ☐ Adoptive ☐ Other:		☐ Biological ☐ Step ☐ Foster ☐ Adoptive ☐ Other:	
Name (Surname, First Name):		Age:		Age:
Mailing Address, including postal code:				
Home Tel #:		Work Tel #:		Work Tel #:
Occupation:				
Language(s) Spoken:		Marital Status:		Marital Status:
	Current Partner:		Current Partner:	
Had Learning Problems:				
Attended Special Classes:				
Emotional problems during school years (specify):				
Any mental health concerns or substance abuse (specify):				

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Siblings: Please list all biological and step-siblings

Name:			Age:	Grade:	Gender:
Relationship:		Problems:			
Name:			Age:	Grade:	Gender:
Relationship:		Problems:			
Name:			Age:	Grade:	Gender:
Relationship:		Problems:			
Name:			Age:	Grade:	Gender:
Relationship:		Problems:			

Biological Family Health Conditions: Check all that apply and identify the affected person's relationship to child.

Condition	**Relationship to Patient**
☐ Attention Deficit Hyperactive Disorder	
☐ Genetic Syndrome/Birth Defect	
☐ Learning/Reading Problem(s)	
☐ Childhood Behavioural Problems	
☐ Speech/Hearing Difficulties	
☐ Physical/Sexual Abuse	
☐ Emotional Problems (specify):	
☐ Other Problems (specify):	
☐ Epilepsy	
☐ Thyroid Problem(s)	
☐ Alcohol Problem(s)	
☐ Drug Abuse	
☐ Repeated a grade	
☐ Migraine Headaches	